To be used with Questions 19(a), (b), (c), and (d)

CHARACTER & FITNESS HEALTHCARE FORM: TO BE COMPLETED BY A LICENSED HEALTHCARE PROFESSIONAL - DESCRIPTION OF MENTAL HEALTH OR SUBSTANCE ABUSE CONDITION OR IMPAIRMENT

Patient's Full Name _____ DOB _____ SSN (Last 4) _____

Date of treatment: From _____ _____ To _____ _____
From Month Year To Month Year

Healthcare Professional's Facility Name _____

Name and title of licensed healthcare professional _____

Healthcare professional's Current address: _____ _____ _____ _____
Address City State ZIP

Telephone: _____

Describe the condition/diagnosis and any treatment or monitoring program for which you are or have treated the above-named Applicant:

Prognosis: Is it your opinion this condition will affect this person's fitness or ability to perform the duties of an attorney in a professional and competent manner?

◯ **Yes** ◯ **No**

i) If yes, please explain

Licensed Healthcare Professional – Print Name

Licensed Healthcare Professional Signature

Date